Appendices

to

The early years
Consultation with providers of early childhood services in the Melbourne municipalities of Yarra, Hume and Moreland

Rosemary Rogers and Jenny Martin

Appendices
Page numbering continues from main report

Appendix 1: NIFTeY: National Initiative for the Early Years

NIFTeY became NIFTeY Australia Inc. in 2001, with a foundation board of Professor Graham Vimpani (Chair) and directors including senior academics, practitioners in early childhood and government representatives from each state and territory. The Victorian director is June McLoughlin, Centre for Community Child Health (Royal Children's Hospital).

The objectives of NIFTeY Australia Inc. are:
1. To promote the development, implementation and evaluation of strategies on the early years of life, that advance the health, development and well-being of all children in Australia.
2. To advance community knowledge and the education and support of parents in relation to the importance of the first three years of a child's life so as to promote the social, cognitive, emotional and physical well-being of all children.
3. To encourage the provision of resources and services to communities and families where children are known to be disadvantaged.
4. To promote and disseminate research relevant to the early years of life, including monitoring the status of young children.
5. To value, recognise and advocate for the importance of the impact of early positive relationships and experiences in young children's lives.

A National Agenda for the Early Years is being developed and will cover:
- why the early years are important
- what are the policy and program implications of our new knowledge
- what can parents and carers do to enhance young children's experience during these years.

Strategies to achieve NIFTeY's objectives include:
- A program of state and national conferences with visits to Australia by key overseas people including:
  - Professor Fraser Mustard, co-editor of *Reversing the Real Brain Drain, Early Years Study: Final Report (April 1999),* Ontario Children's Secretariat, Toronto, Canada.
  - Dr Bruce Perry, author of *The Mismatch Between Opportunity and Investment*, CIVITAS Initiative*,* Chicago, 1996*.*
  - Norman Glass, a former UK Treasury official, closely involved with the establishment of the UK's £520 million **Sure Start** program, a national strategy to support families with children under five in the most disadvantaged communities.
  - Dr Deborah Phillips, co-editor of the National Academy of Sciences (USA) report, *From Neurones to Neighbourhoods: the Science of Early Childhood Development*, 2000.
  - Dr Rima Shore, author of *Rethinking the Brain*, Families and Work Institute, New York, 1997*.*
- Participation in discussions with state and Commonwealth government officials.
- Development of a communication strategy in August 2000.
- Development of a media kit for advocates for the importance of the early years.
- A newsletter.

For more information:
Email niftey-list@newcastle.edu.au or Graham.Vimpani@hunter.health.nsw.gov.au

Appendix 2: Interview Schedule

Agency / Program

1. a. Describe your program(s) for 0 to 3-year-olds and their parents.
   Aims
   Age range
   Activities
   Selection criteria (duration and frequency)
   Location and area covered

   b. In what ways are parents involved?

2. a. Do you have a waiting list? If so, how long currently?
   b. What happens to people on the waiting list? Do you refer them elsewhere? Do you follow up this referral at all?

3. Which of your program users seem most disadvantaged or vulnerable?

4. Which NESB group is the most common in this municipality and/or Region?

5. Which NESB group is the most common using your service?

6. a. For approximately what proportion of families do you use an interpreter?
   b. For which language(s) most commonly?

7. Which vulnerable group(s) is the least common group using your service? Why? What barriers exist?

8. Does your agency, or funder, have any strategies for increasing attendance of the most disadvantaged or vulnerable families with very young children?

9. Which members in a family does the program directly target? :
   a. the parent/s without the child?   Yes / No
   b. the child only?   Yes / No
   c. parent and child together?   Yes / No

10. Has the program been evaluated (e.g. for group or each family's goals)? Yes / No
    If so provide details (Ask for copy)

11. Do you have any written description or other documentation of the program?
    Yes / No
    Please list. (Try to get copies if relevant)

Service System in this Municipality / Region

12. What are particular *strengths* of this *municipality*'s service system, in terms of 0-3 year olds and their parents? Why?

13. What *gaps* exist in this municipality's service system, in terms of 0-3 year olds and their parents? Why?

14. a. How frequently do the following service providers refer 0-3 year olds and their parents to your program(s)?
CC   FDC   MCH   EI   playgroup   CHC   GP   other

b. Which of these are the most frequent referrers?

15. a. Approximately how frequently do you refer 0-3 year olds and their families to the following services?
CC   FDC   MCH   EI   playgroup   CHC   GP   other

b. To whom do you refer most frequently?

Networks

16. What networks (or professional support & information meetings) do you know that exist in Northern Region?

Network name	Frequency of meetings	Frequency of you or another staff member from your agency attending?	Contact person's name and agency details
a.			
b.			
c.			

17. What are the aims of each of these groups/meetings?

18. How useful is each of these Northern Region networks for you? In what ways— give examples?

19. Would you want to change anything about the meetings (e.g. aims; focus; content, leadership, frequency, membership?)

20. What networks exist in your _municipality_?

Network name	Frequency of meetings	Frequency of you or another staff member from your agency attending?	Contact person's name and agency
a.			
b.			

21. What are the aims of each of these groups/meetings?

22. How useful is each of these Northern Region networks for you? In what ways— examples?

23. Would you want to change anything about the meetings? (e.g. aims; focus; content, leadership, frequency, membership?)

24. How well in general do you think that service providers for 0-3 yo children and their families link with other providers in your municipality?

25. What barriers exist to hinder the development of strong linkages between your services / programs and others?

26. What strategies currently, or in the future, might facilitate stronger linkages between service providers?

27. Which services/programs in your geographic area stand out for their ability to reach *vulnerable families* and their young children?
    Why? What do they do?

Strengths / Weaknesses of Service System

28. In this region/municipality, what factors *strengthen* the capacity of the service network to assist vulnerable families and their 0-3 year olds?

29. In this region/municipality, what gaps or limitations *weaken* the capacity of the service network to assist vulnerable families and their 0-3 year olds?

30. Which family groups are missing out most on services they need?
    How do you know this?

Opportunities to Strengthen Service System

31. In terms of improving the educational and life chances of vulnerable or disadvantaged 0-3 year old children and their families, how would you go about trying to change or strengthen the service system in this municipality/region?

32. Is there any new service(s) you might add to the system?

33. How is your LGA planning to use the new MCH flexible "home visiting" funds?

34. Are there any relevant plans, evaluations, reports or ideas elsewhere that we might find useful in identifying needs for 0-3 year olds or ideas for improved services?

Brotherhood of St Laurence

35. What do you know about the various programs run by the Cottage?

36. a. Have you referred any families to their programs?
    b. How satisfied were you with the process and results?
    c. What do you think about these various programs?

37. How are the Cottage programs perceived in the community and by other service providers?

The Cottage is undertaking a review of its children's services in this area, and exploring possibilities for services to disadvantaged 0-3 year olds and their families.

38. As an NGO not tied to specific programmatic funding, what possibilities can you see for the Cottage's role with 0-3 year olds (and their parents) within this LGA (e.g. new program; addition(s) to an existing service)?

39. Do you know anything about family literacy programs?

Additional (if time allows)

This program   (fill out now, or later if short for time at interview)

1. Does the program *exclusively* target disadvantaged families?   Yes / No

2. Which of the following disadvantaged families does the program
   target?
   a. low socioeconomic status   Yes / No
   b. parent with mental illness   Yes / No
   c. parent with drug/alcohol problem   Yes / No
   d. poor parental literacy   Yes / No
   e. non-English speaking background   Yes /No

3. Which of the following does the program involve?

   a. parenting education programs   Yes / No
   b. individual parent modelling and education   Yes / No
   c. parent support (e.g. family counselling, family aids)   Yes / No
   d. home visiting   Yes / No
   e. family literacy activities   Yes / No
   f. child care   Yes / No
   g. child development activities   Yes / No
   h. educational activities   Yes / No
   i. other (specify)   Yes / No

4. Duration of program: (e.g. one year)

5. Frequency of program contact with child (e.g. twice weekly)
   a. with parent:
   b. without parent:

6. Duration of contact time with child (e.g. three hours per week):
   a. with parent:
   b. without parent:

7. Can parents who are working easily participate in the program?   Yes / No

8. Are clients followed up after service completion?   Yes / No
   If so, how?

Appendix 3: List of Project Consultations

DHS, Northern Metropolitan Region (NMR)

- Lesley Hubble, Manager of Children and Family Services; Diane Godfrey (SAAP Program Manager); Janine Harvey; Tina Martin (Children's Services)
- Anne Thompson, Sue Lancaster, Andrew Alford, Leanne Connell, Community Care Division
- Carmel Phillips, Team Leader, Specialist Children's Services
- Liz Sikka, Housing Services Manager, Office of Housing, DHS, Hume
- Suzanne Walsh, Project Officer, PSFO Review, DHS, Melbourne
- Sue Waller, Special Projects, Protective Services
- Lisa Curtis, High Risk Infant Project worker, Protective Services
- Mark Williams, Koori Early Childhood Field Officer (KECFO) DHS, Fitzroy
- Tina Martin, Manager, Universal and Secondary Services
- Linda Goertz, Manager, High Risk Infants Program
- Jan McAffrey Regional Preschool Support Officer

City of Yarra
- Tam Nguyen, Bilingual worker
- Leecy Wolan, Parenting and Children's Worker, Family Support Unit
- Carmen Faelis, Manager of Family Services
- Fay Stanesby, MCH Nurse
- Reay Pressor, MCH Coordinator
- Nick Matteo, Community Planning
- Suzanne Provis & Pat Agostino, Children's Support and Resources Unit
- Louise Stefan, Manager, Youth and Family Services

Community Health Centres, Yarra
- Suong Nguyen, Early Parenting worker & Community Midwife, North Yarra Community Health Centre
- Theresa Ha, Ethnic Health Worker, North Yarra CHC
- Jan Smith, Manager, Casework, Counselling & Community Support, North Yarra CHC
- Vera Boston, Chief Executive Officer, North Yarra CHC,
- Jenny Robinson, Community Midwife, North Richmond CHC

City of Hume
- Jenny Townsend, Coordinator, Early Childhood Services
- Anne Hindell, MCH Coordinator
- Marie Kendall, Community Midwife, Dianella CHS
- Pat Kukulies, MCH nurse, Village Close in the MEWS
- Laurence Alvis, Manager, Community Services
- Joan Myers, MCH nurse

Community Health Centres, Hume
- Man Duong, Bilingual Ethnic Health Worker
- Vicki Goodson, Adolescent Parent Worker
- Ros Stevens, CEO, Sunbury Community Health Centre
- Pamela, Family Counsellor, Sunbury CHC

- Terry Hollingworth, Counsellor, Women's Mental Health & PND, Sunbury CHC
- Chris Kuros, Early Childhood Intervention, Sunbury CHC

City of Moreland
- Paul Turner, MCH Coordinator
- Pauline Borg, Family Day Care Coordinator
- Eugenie Grammatikakis, Access and Equity Officer
- Jenny Merkes, Director of Social Development
- Derryn Wilson, Director, Aged Care
- Jan Barrett, Children's Services Coordinator
- Rosie De Cata & Andrea Polites (CSRDOs), & Sophie Patites (PSFO)

Community Health centres, Moreland
- Alicia Poporevchy, Family Support Coordinator, Moreland CHC
- Joanne Thompson, CHC staff, Fawkner
- Cate Teague, MCH nurse, Reservoir

Other agencies, Yarra
- Fran Ford, Principal, Sacred Heart Primary School, Fitzroy
- Barb Tinney, Social worker, BSL Cottage (& Anglicare), Fitzroy
- Caroline Teehan, Manager of "Choices" Program, Anglicare, Fitzroy
- Barbara Donnegan, Preschool Director, John St Children's Centre, Fitzroy
- Eva Grunden, Director, Annie Todd Children's Centre, Fitzroy
- Priscilla Clark, Multicultural Resources Centre, Richmond
- Creina Porter, Program Manager, Free Kindergarten Association, Richmond
- Tim Gilley & Joanne Donne, HIPPY Program, Brotherhood of St Laurence, Fitzroy
- Anne Horrigan-Dixon, Manager, Learning Exchange, Fitzroy
- Angela Forbes, Manager, Family Support, Kildonnan Family Services, Collingwood
- Warren Cann, Coordinator, Positive Parenting Program, Victorian Parenting Centre, Carlton
- Christina Sadowski & Shar Issa-Farzam, Ecumenical Migration Centre, Brotherhood of St Laurence, Fitzroy
- Alun Wood, Outreach Victoria, Richmond
- Linda Martin, Consultant to Yarra City Council's Family Services
- Gennimaree Panozzo & Nicole Wiseman, Librarians, "Bookstart", Brunswick Library
- Margaret Kenny, Pregnancy Support Service, Good Shepherd Family Services, Collingwood
- Jill Allen, Children's Librarian, Fitzroy

Other agencies, Hume
- Leonie Symes, Broad Insight EI Centre
- Eileen Buckley, Coordinator, Family Day Care, Brotherhood of St Laurence, Craigieburn
- Ebru Unver, Family Support Worker, Turkish Women's Association, Coolaroo site, Dianella Community Health Service
- Andrew Lewis, Coordinator, Infant Psychiatry, MH-SKY, Broadmeadows

- Richard Metres, Anglicare Team Manager, Broadmeadows Family Services
- Alison Andrews, Coordinator, Craigieburn Early Childhood Services
- Julie Gunston, PSFO / Early Childhood Team Leader
- Cathy Pritz, Speech Inc., Broadmeadows
- Lyn Chapman, Andrea & Salvador, Orana Family Services
- Theresa Lazzaro, Community Paediatrician, Broadmeadows Health Service
- Suzie Pinchin, Manager, Neighbourhood Sites, Dianella Community Health Service
- Jackie Carnavo, Early Intervention, Craigieburn
- Accommodation and Support Team, Hume Region
- Phil Conrick, CEO, Broadmeadows Uniting Care
- Leigh Barrett & Jo Grima, Broadmeadows Uniting Care

Other agencies, Moreland
- Lyn Struthers, CSRDO, Melbourne Citymission
- Donna Jacobs, Early Intervention Coordinator - Melbourne Citymission
- Rebecca Ward, Speech Pathologist, Melbourne Citymission
- Sharick Billington, CSRDO, Melbourne Citymission
- Gabrielle Fakhri, VICSEG Program Coordinator
- Winnie Zhi, Chinese Community Development Worker, VICSEG
- Diane Daly, Parenting Educator, Parentzone, Anglicare, Preston
- Margaret Matters, Manager, Service & Professional Development, Anglicare
- Janet Walker, SAAP Homeless Family Outreach Worker, Merri Housing
- Di McLelland, SAAP Children's Worker, Merri Housing
- Naomi McNamara, Community Connections Worker, Merri Housing, Northcote
- Carol Allen, Executive Officer, Kindergarten Parents' Association
- Alishka Sageman, Community Midwife/Coordinator, Northern Birthing Support Service Darebin.

Agencies working across or beyond the 3 focus municipalities
- Jane Miller, Manager of Families First
- Shaza Nur, Counsellor & Welfare Worker, Women's Health in the North
- Rob McGregor and colleagues, Community Connections program, Ozanam Community, North Melbourne
- Theresa Swanborough, Coordinator, RDNS Homeless Persons Program
- Marnie Dixon, Outreach Worker, RDNS Homeless Persons Program
- Jan Adams, Community Midwife, Women's Health in the West, Footscray
- Jenny Rayner, Western Region Field Consultant, Playgrouping Australia.
- Faye Sakaris, CSRDO, Greek Welfare Association.
- Josemann Elmatra, Psychologist & Program Coordinator, Islamic Women's Council
- Muriel Cadd, CEO of Victorian Aboriginal Child Care Association (VACCA)
- Trish Reck, domestic violence Outreach & Children's Support Worker, Berry Street Inc.
- Julie Kun, BSL Koori Aged Care Packages program
- Beryl Thomas, Koori Liaison Officer, Mercy Hospital for Women
- Thea Calzoni, Parent Support Worker, Northern Care & Share
- Melinda Harvey, Coordinator, Westmere Children's Services
- Wendy Brewster, Working Together Program, Uniting Care Connections

- Kim Purdey, Children's Resource Project "Working with Children in Vulnerable Families" support worker, Ringwood
- Lisa Ranahan & Nicole Patton, Children's Resource Project, Wesley Community Contact Centre, Ringwood
- Marisa Bachuk, Victorian Parenting Centre
- Jeanette Hourani, Arabic broadcaster and researcher
- Stella Mulder, Brotherhood of St Laurence
- Janet Taylor, Social Action Research Unit, Brotherhood of St Laurence

Consumer Focus Groups
- Anglicare Choices group for young mothers experiencing homelessness
- Broad Insight Early Intervention agency – group for mothers whose children have a disability or developmental delay
- Turkish women's group who meet with their children at Hume Neighbourhood House
- Group of mothers of children with additional needs in Moreland
- Arabic Women's Parenting group, Meadow Heights, Hume
- Group of Koori young mothers in NMR

Network Meetings, Groups or Forums Attended
- Family Support Forum, Moreland – representatives of the major family support agencies in Northern Region met to plan local collaborative response to the DHS Family Support Discussion Paper
- Planning afternoon at Sunbury with staff and associates of "Local Links" Project
- Domestic Violence Children's Support Workers Network meeting
- Yarra Youth and Family Services Network
- Child Care Coordinators Yarra Network meeting
- Atherton Gardens Residents Association, Services Meeting, Yarra
- Neighbourhood House Coordinators meeting, Moreland

Appendix 4: Social Profiles of Hume, Moreland and Yarra

Table 1   Population Estimates, Hume, Moreland and Yarra SSDs, June 1999

Location	0-4 years	5-9 years	10-14 years	Total all ages#
Hume City SSD				
Broadmeadows	5,524	5,846	5,411	69,074
Craigieburn	3,094	3,398	2,857	32,819
Sunbury	2,406	2,563	2,455	27,696
Total	**11,024**	**11,807**	**10,723**	**129,589**
Moreland City SSD				
Brunswick	2,303	1,799	1,497	41,129
Coburg	3,377	2,979	2,644	49,500
North (Pascoe Vale, Fawkner, Oak Park etc)	3,012	2,858	2,585	46,776
Total	**8,692**	**7,636**	**6,726**	**137,405**
Yarra City SSD				
North (Clifton Hill, Collingwood, etc)	2,178	1,631	1,480	44,412
Richmond	1,185	903	829	24,488
Total	**3,363**	**2,534**	**2,309**	**68,900**
Grand Total	**23,079**	**21,977**	**19,758**	**335,894**

Source: Australian Bureau of Statistics, Cat. no. 3235.2, 30 June, 1999.
#Note: Where this table appears in the main body of the report (Table One on page 10), the right-hand column is incorrectly labelled Total 10-14 years.

Table 1 shows the most recent available estimated resident population figures. The next ABS census will be conducted during August 2001 but the census results at a local government level will not be available for at least twelve months afterwards.

The table shows that in 1999 there were an estimated 23,079 children aged 0-4 years, 21,977 children aged 5-9 years and 19,758 children aged 10-14 years living in the municipalities of Hume, Moreland and Yarra.

Of the children aged 0-4 years living in the three municipalities, approximately 47% lived in Hume, 38% lived in Moreland and 15% lived in Yarra.

Table 2   Country of birth of mothers of children born in 1998 and 1999 in Hume, Moreland and Yarra

Mothers' country of birth	Hume 1998 & 1999		Moreland 1998 & 1999		Yarra 1998 & 1999		Total 1998 & 1999	
	No. of births	% of all births	No. of births	% of all births	No. of births	% of all births	No. of births	% of all births
Australia	2486	62.6	2434	63	1040	60	5960	62.3
New Zealand	56	1.4	55	1.4	43	2.4	154	1.6
England	57	1.4	65	1.7	59	3.4	181	1.9
Greece	18	0.5	35	0.9	15	0.9	68	0.7
Italy	44	1.1	73	1.9	12	0.7	127	1.3
Former Yugoslavia	47	1.1	24	0.6	18	1.0	89	0.9
China	24	0.6	64	1.7	39	2.3	127	1.3
India	41	1.0	28	0.7	6	0.3	75	0.8
Indonesia and Timor	19	0.5	16	0.4	51	2.7	86	0.9
Iraq	112	2.8	137	3.5	<5	0.3	254	2.7
Lebanon	163	4.1	315	8.1	<5	0.3	488	5.1
Philippines	45	1.1	42	1.1	12	0.7	99	1.0
Sri Lanka	67	1.6	76	2.0	<5	0.3	149	1.6
Turkey	351	8.8	114	2.9	18	1.0	483	5.0
Vietnam	91	2.2	37	0.9	223	12.8	351	3.7
Other	361	9.1	351	9.1	188	10.9	900	9.4
Total	**3969**	**100**	**3861**	**100**	**1729**	**100**	**9559**	**100**

Source: Unpublished data obtained from the Victorian Perinatal Data Collection Unit

Table 2 shows the country of birth of mothers who gave birth to children born in 1998 and 1999. These children would be currently aged 2 or 3 years.

The cultural profiles for Moreland and Hume are similar insofar as the single largest groups of mothers born in countries outside of Australia were from Lebanon, Turkey and Iraq, comprising 15.7% of all mothers who gave birth from Hume municipality and 14.5% of mothers from Moreland municipality. The cultural profile of Yarra is quite different from the other two municipalities. In the City of Yarra, there is a higher representation of mothers from Asia: most notably 12.8% of mothers who gave birth during 1998 and 1999 were born in Vietnam and a further 5% were born in Indonesia, Timor and China.

Whilst overall Yarra had the smallest proportion of mothers who were Australian-born (60%), it had the highest proportion of mothers born in New Zealand and England. All three municipalities comprise a very diverse population. Assuming that all of these mothers have remained living in the same municipalities, it is estimated that approximately 30% of the two and three year olds currently living in these three municipalities have mothers who were born in non-English speaking countries.

Table 3a   Indicators of Disadvantage, 1996

LGA	Unemployment rate, June 1996, %	Percentage of Households in Public Housing, 1996
Banyule	5.2	4.2
Darebin	12.4	5.1
Hume	10.0	4.2
Moreland	11.6	2.6
Nillumbik	3.1	0.5
Whittlesea	8.7	1.2
Yarra	7.5	12.7
NMR	**8.9**	**4.3**
Victoria	**7.6**	**3.4**

Source: Department of Human Services, Northern Metropolitan Region

Table 3b   Distribution of Disadvantage within Northern Metropolitan Region, 1996

LGA	Total population as	Public Housing Households 1996	Household Income < $300 per week, 1996	Unskilled Workers 1996
	% of NMR total	% of NMR total	% of NMR total	% of NMR total
Banyule	16.0	15.8	14.3	12.8
Darebin	17.3	22.0	25.5	17.5
Hume	16.5	13.9	10.1	19.6
Moreland	18.5	12.1	25.9	17.6
Nillumbik	7.8	0.7	3.0	5.7
Whittlesea	14.5	3.4	8.5	19.9
Yarra	9.2	32.0	12.7	6.9
Total	100	100.0	100.0	100.0
No. of NMR households in category		10,256	43,720	83,081
No. of Victorian households in category		51,343	294,543	491,269

Source: Department of Human Services, Northern Metropolitan Region

Hume and Moreland LGAs had two of the highest rates of unemployment in the Region in June 1999. The unemployment rates in Hume (10.0%) and Moreland (11.6%) were higher than the regional (8.9%) and state (7.6%) averages.

Yarra municipality has a large proportion of public housing households (12.7%) compared with Moreland (2.6%) and Hume (4.2%). However it should be noted that in Hume, in particular, there are some suburbs and parts of suburbs where almost all households are living in either current or ex-public housing stock. In Yarra, public housing households are concentrated in high-rise flats, particularly in Fitzroy, Carlton, Collingwood and Richmond.

More than one-quarter of the Region's low-income families (with household income below $300 per week, 1996) live in the Moreland municipality.

Table 4   **Distribution of Social Support 1999, Northern Metropolitan Region**

	Population as % of NMR total, 1996	Persons covered by Health Care Card % NMR	Family Auto Payment (families) % NMR	Newstart Allowance % NMR	Disability Support Pension % NMR	Aged Pension % NMR	Carers Pension % NMR
Banyule	16.0	10.4	10.8	9.1	10.9	15.6	10.8
Darebin	17.3	18.5	18.9	21.8	22.5	24.4	22.1
Hume	16.5	20.4	23.2	16.0	16.2	10.4	17.0
Moreland	18.5	20.5	19.2	22.3	22.2	27.7	22.7
Nillumbik	7.8	4.3	3.5	2.6	2.4	3.5	3.6
Whittlesea	14.5	16.5	16.8	12.4	16.0	10.8	17.3
Yarra	9.2	9.3	7.5	15.8	9.7	7.7	6.5
Total*	100	100	100	100	100	100	100
No of persons							
NMR#	699,395	117,083	25,778	31,469	26,760	70,270	1,861
Victoria#	4,354,113	666,158	146,308	159,186	134,964	436,689	10,215

* Percentages in table have been rounded
# Total population figures (only) for NMR and for Victoria are for 1996

Sources: Department of Human Services, Northern Metropolitan Region
Department of Infrastructure *Melbourne in fact: 1996 census statistics for Melbourne's Local Government Areas*

More than 40% of the Northern Metropolitan Region's Healthcare card holders live in the municipalities of Hume and Moreland. Similarly more than 40 % of the Region's families receiving family payments live in Hume and Moreland. Some 38.4% of the Region's disability support pensioners also live in Hume and Moreland. The level of social support is relatively high in the municipalities of Moreland and Hume.

Table 5   Age of mothers of children born in 1998 and 1999, Hume, Moreland and Yarra LGAs

Mother's Age	Hume		Moreland		Yarra		Total		
	1998	1999	1998	1999	1998	1999	1998	1999	1998 & 1999
15-19	80	58	50	43	23	7	153	108	261
20-24	386	266	277	248	54	57	717	571	1288
25-29	785	565	603	500	179	192	1567	1257	2824
30-34	715	515	653	667	353	388	1721	1570	3291
35-39	273	245	345	349	169	223	787	817	1604
40-44	35	43	50	70	32	46	117	159	276
45-50	<5	<5	<5	<5	<5	<5	<10	5	<15
Over 50 yrs							<5		<5
Total	2275	1694	1982	1879	815	914	5072	4487	9559

Source: Unpublished data obtained from the Victorian Perinatal Data Collection Unit (1991)

Table 5 shows the age of mothers who gave birth to children in 1998 and 1999. These children would be currently aged 2 or 3 years.

During 1998 and 1999, 3869 children were born to mothers living in Hume municipality, 3861 were born to mothers living in Moreland municipality and 1729 to mothers living in Yarra municipality.

For the three municipalities combined, some 261 mothers were aged 15-19 years when their children were born, and approximately half of these mothers were living in the Hume municipality. Similarly, of the 1288 mothers who were aged between 20 and 24 years, approximately half lived in the Hume municipality. The above table indicates that, assuming all of these mothers have remained in the same local government area:

- 21% of the two and three year olds living in Hume municipality were born to mothers aged between 15 years and 24 years
- 16% of the two and three year olds living in Moreland municipality were born to mothers aged between 15 years and 24 years
- 8% of the two and three year olds living in Yarra municipality were born to mothers aged between 15 and 24 years.

Table 6 Newly Arrived Migrants and Humanitarian Refugees' Settlement Data, Hume and Moreland LGAs, 7 August 1996 to 12 July 2000

	Hume	Moreland	Total
Iraq	513	547	1060
Turkey	403	208	611
China PR. (inc. Hong Kong)	82	450	532
Lebanon	112	248	360
Sri Lanka	101	134	235
Philippines	93	112	205
Former Yugoslavia (inc.Serbia)	95	75	170
Somalia	104	50	154
India	78	61	139
Vietnam	66	45	111
Bosnia and Hercegovina	41	53	94
Syria	42	40	82
Fiji	49	28	77
Italy	14	53	67
Pakistan	13	54	67
Croatia	17	36	53
Egypt	17	25	42
Indonesia	15	19	34
Iran	8	25	33
Greece	3	26	29
Malaysia	14	12	26
Singapore	16	9	25
Eritrea	5	16	21
Total (includes countries not detailed in chart)	2156	2876	5032

Source: DIMA Settlement Data Base

Over the period 1996-2000 there were more newly arrived migrants and humanitarian refugees moving into Moreland (2876) than Hume (2156). The biggest single cultural group that moved into the Hume and Moreland municipalities was from Iraq. The second biggest group that moved into Hume was from Turkey and into Moreland was from China. For both municipalities, newly arrived migrants and humanitarian refugees came from a wide range of countries.

Table 7   Projected Population Change, Hume, Moreland and Yarra

	Percentage population change 1996-1999				Percentage population change 1999-2006			
	0-4 years	12-18 years	65+ years	All persons	0-4 years	12-18 years	65+ years	All persons
Hume	-5.0	4.1	16.2	4.6	-9.0	13.5	31.4	9.6
Moreland	-4.0	-0.6	4.0	0.7	-3.4	6.0	4.9	4.3
Yarra	-15.1	-4.8	1.2	1.2	-0.9	-11.3	4.3	3.8
NMR %	-2.2	0.6	5.6	2.2	-4.6	4.1	12	5.7
NMR change in numbers.	-1,136	392	4,456	15,780	-2,343	-2,728	10,076	42,722

Source: Department of Human Services, Northern Metropolitan Region

The population projections show that, on current trends, for Hume, Moreland and Yarra there will be a reduction in the number of 0-4 year olds living in these municipalities—especially in Hume—over the period to 2006.   There will be significant increases in the over 65 years age group.   Hume and Moreland will experience a notable increase in the 12-18 years age group over the next few years.

Appendix 5: Case Study – Multi-lingual Ethnic Health Outreach Worker, Hume

Man Duong is an ethnic Chinese/Vietnamese woman with a strong professional background. She was originally appointed to the Hume MCH Outreach team to assertively outreach to mothers who had prematurely stopped regularly coming to the MCH centres. In this initial role, she identified Chinese and Vietnamese families and visited them regularly until she gained their trust. She helped to link these families to the MCH service for issues such as nutrition and parenting.

Three years ago Man set up playgroups in Hume to reduce the social isolation of Vietnamese and ethnic Chinese women. She suggested regular groups for woman and children, which decreased their isolation considerably, and she organised bus transport for them to the local MCH/Child Care centre. Groups had a loose structure, and had a guest speaker most times, e.g. from the Union on women's rights and from Parentzone on parenting. Membership was open (i.e. families could come and go). The playgroup still runs, generally for 3 to 4 year olds. Many of the women became more confident, less isolated and more empowered. Playgroups explored issues like domestic violence, relationships and other concerns. Several of the women managed to find employment for the first time in Australia.

Man has also run parenting programs as interpreter/facilitator in Chinese and Vietnamese, as well as mothers' support groups for Vietnamese home sewing workers, whose children are isolated.

She now works more broadly and links women and children to other services, e.g. early childhood intervention workers and childcare, not just MCH. Man encourages older children to access kinder: she obtains enrolment forms, and even goes to interviews with parents and the teacher. She has encouraged her women to attend AMES English classes (free for migrants within first 5 years of arrival, with free childcare). During 2000, Man and a speech pathologist from Dianella CHS ran an 8-week, 2 hours per week language delay/speech group for parents and children in Vietnamese. She now works with the new Enhanced Home Visiting MCH nurse (O.3 EFT) with women who disclose domestic violence.

The local Vietnamese and ethnic Chinese families tell Man about area newcomers so she can help them get settled and link them to services for help.

Appendix 6: Home-Start Australia – Home Visiting Program

Home-Start is a voluntary organisation in which volunteers offer regular support, friendship and practical help to young families under stress in their own homes, helping to prevent family crisis and breakdown. Each family has at least one child under the age of five years.

The first Home-Start scheme was established in Leicester, England in 1973 and there are now 196 Home-Start programs operating throughout the United Kingdom and other countries including Germany, Gibraltar, Canada, Netherlands, Hungary, Israel and Australia (five in NSW and one in the ACT).

Each Home-Start scheme is rooted firmly in its own community with at least one paid coordinator and an administrative assistant, working with a ratio of one paid coordinator hour to one volunteer. Each HOME-START scheme has a multi-disciplinary management committee as employer, which includes local representatives from government and non-government agencies.

Home-Start places considerable emphasis on preparation and support of volunteers. This produces volunteers who are committed and competent, which in turn ensures continuity of visiting and long-term time and care to individual family members.

Each Home-Start scheme works towards the increased confidence and independence of the family by:
- offering regular support, friendship and practical help to families with children under five
- being available to families who are experiencing frustrations or difficulties
- visiting families in their own homes where the problems exist and the individual's dignity and identity can be respected
- developing a relationship with the family in which time, flexibility of approach and understanding can be shared
- encouraging the parents' strengths and emotional well-being for the ultimate benefit of their own children
- reassuring parents that difficulties in bringing up children are not unusual and emphasising the pleasures of family life
- encouraging families to widen their network of relationships and to use community support and services effectively.

Structure and management of Home-Start Schemes

Each local scheme is based firmly in its own community, with local funding, volunteers and management committee members. All Home-Start schemes share a common ethos and constitution. The structure of Home-Start requires a multi-disciplinary Committee, at least one paid Coordinator and 2 groups of committed Home-Start volunteers.

The local Committee is made up of representatives from government and non-government agencies (working with under-5s and families), individuals with specialist skills and Home-Start volunteers. This group ensures close liaison with others involved in work with young families in the community. The management committee also
- adopts the constitution
- secures adequate on-going funding for the scheme
- finds suitable premises

- employs a Coordinator and suitable administrative assistant
- take out adequate insurance cover
- ensures that high standards of practice are maintained.

Coordinator

The paid Coordinator of each Home-Start scheme works closely with the Management Committee and plays a key role in Home-Start locally. It is the Coordinator's responsibility to recruit and select a team of suitable volunteers, to coordinate their Preparation Courses (usually one day a week for ten weeks), to provide opportunities for ongoing training and individual and group support.

Families are generally referred to Home-Start by various helping agencies, e.g. maternal and child health nurses, social workers and family support services. Other referrals come from schools, pre-schools, churches, doctors, neighbourhood centres and self-referrals. The Coordinator then visits each family to discuss their needs before introducing their Home-Start volunteer to them. One Home-Start Coordinator is able to support approximately 45 families through a team of 35 volunteers.

Volunteers

Home-Start volunteers, who are normally parents themselves, undertake a ten-week Preparation Course before being carefully matched to one or two families. They visit families with at least one pre-school age child, who are experiencing difficulties or frustrations. By visiting the families at home, volunteers are able to establish a trusting relationship through which they can work with the families, building up the parents' self-confidence and ability to cope, helping them to make use of the community facilities and resources and to enjoy their children.

For more information
Information is available from Home-Start Australia
Marilyn Barnes
The Family Action Centre of the University of Newcastle, New South Wales.
Web site: http://www.home-start-int.org/Australia/home.htm

Appendix 7: DHS New Initiatives Funding to MCH Home Visiting in Yarra, Hume and Moreland

There have been two recent funding sources (DHS) for MCH Home Visiting:
1. New Initiative (NI) funding circa 1998 (to a limited number of MCH services)
2. Enhanced Home Visiting (EHV) funding in late 2000 to all municipalities.

City of Yarra

Yarra allocated their EHV funding according to a needs-based formula. It is being used to fund a 0.6 EFT MCH nurse with a broad role, including responding to breastfeeding, post-natal depression and social problems. The project included the following strategies:
- Project started looking at non-attenders at MCH, targeting 0-3 year olds.
- Written questionnaires were sent to random 10% of all MCH mothers in Yarra. Return rate was about 50%.

Other aspects of the Yarra MCH Service include:
- Good referral system
- MCHN nurses receive monthly "supervision"
- Planning Positive Parenting Program (PPP) training for 2001 – for all MCH nurses
- No restrictions on number of client visits, i.e. "open door" policy
- Approximately 50% of First Time Mothers' groups go on meeting after MCH withdraws.

City of Hume

Hume received funding from both of the DHS Initiatives mentioned above:

1. **New Initiatives funding** was used for:
- an adolescent worker (0.6EFT) to work with teenage mothers;
- a bilingual ethnic health worker (0.6 EFT) to outreach to mothers with a child (0-1 years old) who were not attending the MCH nurse regularly (see Appendix 5);
- a one day per week day stay program (from Tweddle Early Parenting Centre, in a Hume-based locality) where mothers with a child 0-3 months and 7-9 months have been the largest users. Problems being addressed are mostly sleeping, settling, parental tiredness and lack of confidence, and lack of routine. Families can self-refer or referrals come through MCH nurses and some GPs.

2. **Enhanced Home Visiting funding** (of $30,000)
Objectives of this funding are to:
- Provide support for vulnerable families in the target group, i.e. mothers with baby under 3 experiencing difficulties or baby discharged from the High Risk Infant program; parents with baby under 12 months experiencing a crisis affecting their ability to parent effectively);
- Improve skills and confidence in parenting, working with either individual families or groups;
- Improve early detection of problems and ensure early intervention by linkages.

In Hume, this funding is being used to:
- Undertake a needs analysis for services for vulnerable families, using broad consultations with own MCH nurses, other agencies and consumers.

- Demonstrate the need for MCHN services to update and inform other agencies regarding its service and its focus (e.g. evening consultations; first-time mothers groups & New Initiatives programs).
- Assist the MCH nurses to consult & reflect; which led them to identify the need for an outreach program to complement and extend current home visiting program.
- Re-deploy a current MCH staff member for the new position (0.3 EFT), with an emphasis on women who disclose domestic violence, while the rest of the funding goes to enable other MCH nurses to do extra home visits .
- Use some of the bilingual ethnic health worker's time to work with the MCH worker with a focus on women who disclose domestic violence.
- Focus on the use of a family-focused background and clear process for referral in and out of program.
- Trial a new ecological family assessment model and parenting assessment tool.
- Strengthen partnerships between the MCH service, parents and other community support agencies.

City of Moreland

Moreland did not receive any of the first New Initiatives funding.

Enhanced Home Visiting funds were used to:
- Appoint a new MCH nurse for the Home Visiting position
- Employ a full-time Family Development Worker.

Their overall aim is to enhance family functioning, parenting and life skills of vulnerable families with children aged 0-1 years in Moreland.

Moreland's objectives for the funding are:
- To provide information, education and practical support in areas of need identified by families including the areas of safety, hygiene, nutrition and immunisation.
- To improve parent-child interaction, relationships with extended families and connectedness with the wider community.
- To improve families' confidence and competence in knowledge and skills in parenting.
- To assist parents to increase self-esteem, and self-confidence.

Other aspects of the Moreland MCH Service include:
- Aim to increase links with preschools e.g. to do immunisation there, and possibly present a MCH certificate to the preschool.
- Considering extending the co-location of MCH nurse, library, preschool and childcare.

Appendix 8: Case Studies – MCH-Facilitated Mothers' Groups Developing Independence

1. Darebin young mothers' group

Facilitated by Cate Teague (MCH nurse) and Stella Auram (Youth Services Coordinator)

History:

There are many teenage mothers in Darebin but few came to First Time Mother (FTM) groups, despite having above-average needs. They did not tend to use other services either. Any parenting issues were referred for one-to-one, short-term handling by Strengthening Families (SF) program. Cate Teague approached SF to help run a special FTM group, which started as a pilot in August 1999. She found a suitable venue: a youth resource centre with a worker who happened to have funding for a "women's project" ($3,000) and agreed to use that funding to continue the group after the SF funding finished. Together they planned the group. Twelve mothers attended for 8 sessions, and the two staff met and planned each session between weeks. Sessions included:

- warm-up, introduction, needs / wants from the group
- "Mums, young people, and baby stuff"
- Session on "Sex Lives and Body Change", including contraception, body image.
- Games and warm ups run by the youth worker
- "Limit setting for toddlers", during which they role-played lots of scenarios – very visual methods as some of the group were semi-literate.

The pilot 8-week program went well overall, although the mothers were very vocal and it sometimes got fiery. They decided they needed group rules. The pilot group ran until the end of September (1999) then stopped.

Becoming independent:

The MCH nurse's long-term plan was to get commitment from Council for the group to keep going. Eventually the Council agreed to provide another $3,000. Leaders and the young mothers had a Christmas party and all the group wanted to continue.

In 2000, Cate and Stella co-facilitated group meetings for six months, so successfully that they now had 23 members. They combined activities with education and health promotion, e.g. dental care and cooking. Children were 0-3 years old. Realising the mothers were fearful or distrustful of service providers, the leaders invited Family Day Care and centre-based childcare staff to explain and de-mystify their services. The young mothers' understanding of child development was very poor. They could not at first see that separation anxiety was actually a developmental milestone. childcare was paid for the women, using $1,600 from youth centre funding. During the first half of 2000, various issues affecting children emerged, e.g. children with behavioural problems, developmental delays, parental literacy, little stimulation and some drug issues (alcohol and cigarettes). Some of their children were now displaying developmental problems.

By second semester 2000, subtle changes in their parenting had gradually occurred. The big difference now was that the mothers supported each other and had a large network. The women had increased their self-esteem, and had opportunity to observe their child's play and development. Later in 2000, council gave another $3,000, which funded things like childcare, excursions, rental, some speakers, nutrition, massage, but not the facilitators' time. The two started to plan slow changes

working towards the group's independence. They had got to know the young women very well, so that trust had formed. Half of the children were referred to early intervention programs with the mothers' consent.

In 2001, the group gradually moved towards a playgroup. The young mothers still needed to enjoy their own youth activities, and still needed a level of support, or else the leaders thought the group would wind up. They started having playgroup at the MCH centre. The mothers run it (10-12 am Wednesday) and are often still there at 1 pm. The MCH nurse has "young mums' open session" at the same time, and other young mums (not from original group) can come too.

The MCH nurse is accessible, and follows up or refers appropriately. The group has registered with the Playgroup Association, who gave them some toys (with some extra funds from the youth worker). The playgroup now has 32 mothers. It costs the mothers $1 per week; and they have a treasurer and secretary to organise the playgroup. They bring their own food and drink. A Children's Services Resource and Development Officer (CSRDO) came informally to play with the children and the young mothers can ring her occasionally for support.

In addition, a new group of young mothers has formed. Most have come much earlier in their baby's infancy, so there is opportunity for very early intervention this time. It is expected that they will form their own playgroup at the end of the year. The total membership of the two groups in 2000 and 2001 is 32 women.

With help from the Family Services Manager, Cate and the other facilitator applied and succeeded in getting some Commonwealth (FaCS) funding. From the original group, three children are going to preschool next year. A social worker now attends from the Community Health Centre, and she can interview clients as required. About three of the original mothers are working; and 50% are still with their partners.

Facilitators' comments on the project:

- Engagement of these women has been the key. This is a hard and slow process, which involves gently getting to know the group and acting on their stated needs to gain their trust and confidence.
- The MCHN liaised with other MCHNs to do home visits to try to recruit young mothers.
- The women need supervision with play, due to having been poorly parented themselves.
- Many professionals (e.g. MCHNs) are not trained or confident to run groups. FTM groups' success depends on facilitation skill of MCHN, and flexibility is needed.
- It is important to be able to access some funding e.g. small grants from local Council (for venue or childcare; excursions; speakers; room hire). The MCHN would need some extra funding for her work, or for a replacement at her centre.
- Development of linkages with other service providers is needed, to invite workers to come to the group to de-mystify their service and role, and also to increase access and referral to their services.

2. MCH nurse in Westmeadows Public Housing Area, Hume

Pat Kukulies runs playgroups for families living in Office of Housing units in Westmeadows, in Hume municipality. She believes that about 50% of the units there have families who could be using MCH service but are not. The mothers are poor attenders of the MCH service, despite reminders and even hand-delivered invitations. It is mainly Australian-born mothers who attend, as well as some mothers who are Turkish and Arabic .

She first tried starting a group for mothers and young children in early 2000 but nobody came, even though she had hand-delivered 90 invitations to every unit in the Mews Estate (Tunbridge, Swindon and Barnsley). Pat had made several attempts to reach these families. First she tried starting a group which she called a "*playgroup*". She tried to make it so that the mothers would feel comfortable e.g. she tried to have informal chats or have a video playing in the background while the children played. It was run in her centre, next to which is a community hall with occasional childcare. A bus runs past the Mews. She thought that access to this venue would be relatively easy for the mothers, as those from Barnsley and Swindon Mews could just walk across the road, although Tunbridge Mews is a bit further away and up a hill via some steps.

She tried again in July/August 2000, with a letter drop to all households. Nobody came the first week; but the next week she had two inquiries and then had two families come to the group. By early 2001, she had five families attending, all from the Mews. They were relatively young mothers of whom Pat knew two from their first babies and the other three were first time mothers. The group had been advertised for children between 2 and 5 years old. The children in this group were 2 and 3 year olds, and the two younger siblings were babies (between 6 and 12 months old). Later in 2001 there are nine mothers with 14 children, including four babies.

Pat still runs most of the activity group ("playgroup"), and now the mothers end up playing themselves. The mothers started copying their children with painting and play dough, while chatting among themselves She uses local free and natural "toys" like leaves and twigs, and play dough, with the recipe for the mothers to take home, to demonstrate to them that playthings do not need to be costly. The mothers are just starting to take turns running an activity.

The group is a very unstructured one, with three to four activities each week, and the children are able to choose activities. At first, only some mothers talked, because they already knew each other.. The mothers talked about things like their living conditions, safety, and the level of drug dealing in the area. Lately, discussion about MCH issues comes up within the group. At the time of the project consultation, the group has been running for 7 months, with the mothers starting to ask about appointments (and then turning up). They talk about issues around the children (e.g. immunisation, diet or developmental issues). The children are now happy to sit and listen to a story and "sometimes even request another one".

One mother that arrived after the group had started was Timorese; she had been in Australia for several years, and in Hume for 2 years, and was still very isolated). All the mothers feel quite isolated in the Mews. Parents do not like going outside: they feel threatened by older children, by the drug-dealing and prostitution, and are concerned about very young children who roam around without supervision. Effectively the Mews is *not* transitional housing, because moving out is very difficult. Families do not like living there: "If I had money I would move out quick smart" seemed to summarise people's attitude to their area.

Other services in the same area

Pat knows the community midwife at Dianella CHS and has worked occasionally with her. Pat also knows of the adolescent parent worker who runs a mothers' group elsewhere.

Tenancy Outreach started running exercise classes at Banksia Gardens with the help of their only attached worker. 6 months later, a woman from Tenancy Outreach (Bedford St Outreach) organised "clean up" days; football in school holidays; and Christmas parties.

Appendix 9: Case Study – Playgroup within a Community Development Project, Moreland

The team of workers involved from the Moreland Community Health Centre were Alicia Poperechny, Helen Spence and a casual children's worker, Merilyn Penhalluriack.

Background

In the three public housing estates in Moreland, there were difficulties for families in accessing services. Workers knew that families did not access neighbourhood houses; parents did not, on the whole, send their children to preschool or childcare; there were difficulties between these families and the schools; and these families made little use of the MCH Service. In response to these issues, the Moreland Community Health Centre family support service (MCHC) decided to change their focus, targeting these families and using an outreach model. Parenting programs run through neighbourhood houses had attracted mostly well functioning families, keen to enhance their parenting skills, but had been unable to target high need families.

Beginnings

The team realised that a simple letter drop would not be effective so they door knocked every home in the three housing areas. There was a lot of suspicion: families seemed fearful and wondered if the workers were from Child Welfare or Centrelink. Nobody had ever visited them before to ask their opinion about services. It took time, patience and careful presentation. Workers avoided using the term "parenting" and instead asked people if they would be interested in "social groups with children" and the chance to talk about "What is it like to be a parent in Gronn Place?" Gronn Place was chosen as the base for the project, because this estate had the highest number of 0–5 year olds; 80% of the children had not been to preschool; and the estate also had the highest number of single parents and of newly arrived CALD families.

Finding a venue for the group was hard until finally the local senior citizens' centre became available. The plan was for the group to meet every Friday, for the whole year. On the first day, half an hour after starting time, no-one had arrived, but by the end of the session, five families had straggled in, though some only stayed a short time. Initially it was hoped that the parents who came would engage with their children in play activities, and the group became known as a "parenting playgroup". However, it was soon obvious that the workers needed to play with the children so that parents could have some time out. Engaging the children was a strategy which enabled trust to develop between parent and worker. For some families this trust developed very slowly and a number of weeks went by with them simply observing without contributing to the group.

Though families had demonstrated some trust by turning up, they were not yet engaged in the program. Workers realised they needed to respond to the mood of the particular group on the day and initially no set program or format was followed. Key early icebreaker questions, however, led to an outpouring of responses, often angry and loud. The questions, simply put, were "What's it like living in Gronn Place?" or "What's it like being a parent at Gronn Place?". Responses were written up on butchers' paper, and the more that was said, the more came out. There were lots of grievances and this was the first time these particular families had been asked their opinions.

An emerging group structure

Once workers were told about the issues they felt they had a *mandate* to work, and a clear *responsibility*: to respond to these issues. So a process evolved, which was managed sensitively and consistently.

- For each issue raised, the group decided on a response. Often, the families identified that they needed people from the relevant service to come and listen and be prepared to take some action. In Alicia's words, they wanted someone to "come and walk the walk with me".

- The first issue to address needed to be one which could lead to success – tangible, visible and immediate. This issue turned out to be syringes, rubbish and general hygiene on the stairwells of the estates.

- The next key step was inviting the service provider to come out of their own comfort zone, and to hear directly from the families how their service was experienced on the ground. This was empowering for the families because at the end of the session they felt confident they knew someone to approach when they needed something (e.g. the representative from the police force handed participants cards with names to which they could now put a face) . For the service provider it was an opportunity to make real and positive connection with families they were often confronting in a hostile atmosphere.

- Next came a discussion about 'homework': what follow-up was needed and who was going to do it? At first the workers took on the homework responsibilities. One worker agreed to contact the appropriate housing official to attend the next meeting. This was recorded and it provided the focus for the next week session which opened with a report back on homework. Gradually, homework started devolving to group members, e.g. someone would offer to bring another they knew who had been affected by this issue; someone else would offer to help a group participant with a small baby who often needed help getting down the stairs, etc. The same process was used – things were written down and the next session began with feedback from homework.

- It was agreed that the MCH nurse would come every second week and simply be part of the group informally. These dates were advertised on a printed sheet and in fact more participants attended the group on these days.

- The only rule was that information was confidential unless permission was given for it to be shared. Issues around responsibility for children during the meetings were worked out as the group developed. As parents came to trust and value the way in which the childcare coordinator worked, they would back her up by reinforcing an instruction she had given to their child.

- The project worked with a total of 22 families, with a core group of eight families regularly attending. Only two of the families spoke English confidently, and families had Turkish, Eritrean, Cook Islanders, or Lebanese as their first language. Families chose not to work with interpreters.

Keys to effectiveness

Over time, the following themes emerged.
- The need for appropriate and flexible childcare activities, provided by a highly skilled and confident worker emerged early. It seemed that many of the children had not been in structured activities before. The first few weeks were very chaotic, with children described by one worker as "feral" there was a lot of yelling, hitting, running, with nobody quite knowing how to react. One worker, highly skilled and highly motivated, moved on because, in her own words, she "had not worked with children like this before". Another worker, with significant experience as a youth worker and who could "speak the language" of these

children, was invited to participate and she was able to gradually build rapport with parents and children. Enormous flexibility and creativity was required as children came and went (during the session, as well as between sessions). Also, children ranged from babies to 4 year olds and the groups often included older children.

- Alicia learned when she worked in Pentridge, that if you are going to get anywhere you cannot be an outsider who comes and goes. In practice this meant things like visiting the home where the toilet had been leaking for months and pursuing the issue until it was resolved, keeping the families involved and informed at each step.

- A key learning was that because the issues were presented by the group to the service representative, the support and anonymity of the group made it possible for many participants to speak up. They did not have to speak as the individual affected – the grievance was often spoken about as "a friend of mine…someone I know".

- At the same time, the service representatives were carefully chosen by the workers as people accessible and motivated to make a difference to the lives of these families. They were called to account for the homework they were given and at times this was difficult for the services. These "reps" often needed careful briefing and de-briefing. The whole process was a journey of discovery for everyone, as services who prided themselves on being accountable and accessible often received some unpalatable comments and were required to confront some critical realities.

- On one occasion a workers, noticing how restless the group members were becoming, interrupted the speaker, saying "Bill, I don't understand what you are saying…". Bill modified his language and was able to re-connect with the group. The role of the workers became much less directive as the group developed.

- Feedback from the service providers seemed to fall into two quite different groups. From those closest to the families (i.e. more direct service providers) the response typically was that they realised how much harder they had to work to enable these families to easily access their services. By contrast, more remote service providers tended to respond that "opportunities were there if people wanted to use them".

Outcomes

- There were some very clear examples of sustained change for individual participants. One woman came and sat and said little for several weeks. Then when housing issues close to her experience were being discussed, she spoke, hesitantly and others joined in. When a public forum was held (to which the families went by bus) the woman spoke nervously again to a much bigger audience, and people in the audience spontaneously began to clap and commend her for her courage. She is now an office bearer on the local Tenants Union.

- A number of service providers realised they would have to work harder in the future to live up to their reputation of being "genuinely accessible." They seemed to take up this challenge with enthusiasm.

- Some new opportunities were negotiated for the participants as an illustration that "funding a small change can lead to policy change". Examples include:

- Gronn Place families had never before been to the swimming pool (managed by the YMCA), as school excursions cost money and the children had stayed away. These families now regularly have swimming lessons for their children and themselves, paying what they can afford.

- The local cricket club has developed a relationship with an emerging Gronn Place junior football club, though other sporting clubs approached were not interested.
- Families heard about community gardens and visited several together. They began to construct their own Gronn Place Community Garden, which opened in April 2001.
- The Council have organised a bus to pick up young people (girls from Muslim families as well as boys) to take them to activities organised by Council.
- A number of children are now enrolled in preschool through an arrangement with the local preschool about fees.
- Several parents now use the neighbourhood house, having met the convenor at their group, who explained the "pay as much or as little as you can afford" policy. These parents had assumed there would be nothing for them or had not known what was offered.
- There are now some places set aside for Gronn Place residents in the very popular school holiday programs, which they had not previously accessed. A Turkish women's group has formed out of the experience.

Discussion

Key factors in the project's effectiveness seem to have been the facilitators' decisions:
- to acknowledge that mainstream parenting approaches were not appropriate, and that new approaches needed to be found
- to accept that engagement may be time-consuming and confronting, and that a commitment was required to stay the distance and "walk the walk" with participants;
- to ask the simple but confronting question of "*What's it like being a parent around here?"* and to be prepared to really listen to the answers
- to work in a collaborative way with participants, to develop solutions to the difficulties raised; and
- to be flexible – for example, initially an "early childhood approach" to playgroup was adopted, but a "youth work" approach seemed to be more suited to the needs of the group, and so was adopted.

A less direct aim of the project was to foster *inter-generational change*, by encouraging parents to send their children to preschool. Two challenges emerged:

The first was how an outsider can introduce ideas about preschool, when families believe that preschools are too costly or not a priority. What worked in this setting was the notion of preschool as an enrichment, and an addition to the family value system, rather than an imposition. The possibility of doing something the families had not done before was introduced by workers coming to families and inviting them to participate. It was done in such a way that it did not threaten the families' sense of themselves.

Secondly, there was a commitment from the facilitators to advocate that *the change be funded.* Alicia clearly told service providers: "If you want this change to happen, *someone has to fund the change".* So, if the next generation is to have a different value (say, around preschool participation), funding for this participation has to be provided, otherwise, the next generation is not likely to maintain this different value.

A final observation will be familiar to anyone who works with marginalised families. The Gronn Place families did not know what they could have, and they did not know how to go about accessing services. So they were put off by barriers or perceptions of services they had in their own minds.

Appendix 10: Northern Birthing Support Service (NBSS)

Provider: North East Community Health Centre Alliance
Darebin, Hume, Banyule, Whittlesea Community Health Services

Funding Source: State Department of Human Services (major)
Community Health Services; Hospitals (3)

Locality: Hume, Banyule, Darebin and Whittlesea municipalities. Note: Moreland CHC is not part of the NBSS consortium.

Target group: Women who are: newly arrived migrants, teenage mothers, physically or intellectually disabled, at risk of abuse, experiencing chemical dependency, socially isolated, experiencing multiple births, have a poor obstetric history, have experienced a recent perinatal death, have DHS involvement, have a history of postnatal depression.

Aim: To provide community midwifery in the Northern Metropolitan region of Melbourne.

Purpose: To act as a bridge between the acute and community health sectors for birthing services in the Northern Metropolitan region of Melbourne.

Duration: Commenced 1996. Currently (2001) under review with longer-term strategic plan being developed.

Overview

The Northern Birthing Support Service (NBSS) provides a birthing support service for high needs families in the municipalities of member community health services. This is provided by a community midwifery service to the target group.

NBSS was initially funded by DHS for 3 years. It has been evaluated twice and is now under a steering committee consisting of the four Chief Executive Officers of the participating Community Health Centres, plus a representative of Maternal and Child Health Coordinators, and Divisions of General Practice (North East and Northern).

Since the demand is high and the role is labour-intensive, NBSS targets those most in need. Assistance is provided to clients from conception to birth, including the birthing process. The family stays with the NBSS until the child is 6 months of age (or in some cases longer, at the discretion of the midwife). The NBSS coordinates the work of each community midwife who remains accountable to their community health service.

The NBSS care coordination framework consists of the following core activities.
- Advocacy/referral
- Assessment/needs identification
- Planning
- Linkages/secondary referral
- Review

- Closure of case.

The NBSS offers women the following services:
- Pregnancy, childbirth and parenting education in a self-directed learning environment
- Clinical assessments and care
- Assistance to material and financial aid
- Referral
- Information regarding other services for families and children
- Options for maternity services
- Assistance in accessing housing services and agencies
- Breastfeeding and artificial feeding support and advice
- Parenting advice
- Outreach service with consultations in a variety of locations
- Accompaniment to hospital/doctor appointments
- Some assistance with transport services.

Family support is provided in the antenatal period. This is important in reducing family stress both prior to and after the birth of the child

Discussion

The advantages of this service are evidenced in its capacity to provide culturally appropriate care to women, the opportunities for midwives to work in partnership with other disciplines, increased opportunities for women in the target group to access childbirth education and to promote breastfeeding.

NBSS combines a community development approach with health promotion and early intervention. It is a highly successful service and could link in well with early parenting and support services provided for the same target group. All community midwives have had formal education in both midwifery and community health and most in Victoria are employed in community health centres, but some are in positions where they are not fully utilising their educational qualifications.

Potential advantages of CMWs' joint roles are as follows:
Located in Community Health Centre, they may be able to provide services to their mother clients over some years if they have other problems.
- They have the potential to offer longer support to mothers and babies/young children over time and to complement the MCH standard visits.
- Their main role is home-visiting to **disadvantaged** families. They mostly see women in their homes, and can address a range of needs of mothers.
- Their role may include working with mothers **before** birth in childbirth education—including one-to-one education for CALD mothers, mothers with an intellectual disability or other high needs
- Their antenatal education role with expectant mothers enables them to make linkages to other services before the birth, including those more culturally appropriate and in their own community
- One of their core roles is to provide assistance to disadvantaged groups such as refugees.

Community Midwives have taken on very diverse roles, including:
- identifying and linking some of the most disadvantaged mothers to MCH home visiting services
- taking referrals for "cultural confinements" from MCH nurses soon after childbirth to make several home visits

- working with new refugees through Foundation House
- working with families with Temporary Protection Visas, which often involves considerable effort linking them into children's and family services.

One Hume CMW estimated that 30–40% of her time is spent working with parents with an intellectual disability. These parents may have poor organisational skills, handling transport and other difficulties. Protective Services often receive reports on parents with an intellectual disability, and they involve this CMW in case conferences. Continuity of care is especially important for these parents. Because the CMW is visible within her employing community health centre, parents can drop in and keep in touch. Some mothers have a disability worker allocated from Child Protection, who helps with budgeting and home visits, but other mothers do not want a disability officer and are very isolated. The CMW persuades the mothers with ID to place their child in childcare as their Disability Allowance has funds for that service.

Appendix 11: Eligibility Criteria / Priority System for SCS in Northern Metropolitan Region (1998)

This document (key parts of which are presented here) indicates the eligibility for intake priorities for Specialist Children's Services teams. Families assessed as Priority 1 or 2 are deemed eligible, while those assessed as priority 3 will be deemed ineligible for SCS services.

Priority 1 Child and family needs are **high**, requiring:
- Multi-disciplinary service provision;
- Intensive one-to-one service provision, at least initially; and
- Family service coordination; or
- Immediate intervention due to high medical needs.

Child's development is showing signs of **severe** delay in one or more areas. For example:
- Referral from paediatrician who has assessed child as having delays in all areas of development (12 months or more)
- Child requiring autism assessment; diagnosed with Spastic Quadriplegia; diagnosed as visually impaired; no head control; child at 3 years who uses no word and plays alone at child-care
- Extreme behaviours, likely to be long-term and associated with a developmental delay/disability, e.g. child with developmental delay with head banging behaviour
- Urgent situation where child's condition places family in crisis
- Recently diagnosed syndrome/disorder e.g. Down Syndrome; Cerebral Palsy.

Priority 2 Child and family needs are **moderate** and require:
- Moderate to intensive service provision;
- Involvement from one or more disciplines; and
- Less immediate intervention.

The child's development shows signs of moderate delay of approximately 6–12 months in one or more areas. For example,
- Child attending kindergarten, with delayed development of about 6 months, for whom a home-based educational service has been requested
- Situation where child's development is being addressed but family needs support to deal with conflicts/issues arising from the child's presenting difficulties.

By comparison, **Priority 3** Child and family needs
- Are minimal;
- Do not require multi-disciplinary service provision; and
- May be met by community agencies.

Developmental concerns are **minor**.
For example:
- Request for psychology for child bed-wetting for child under 5 years;
- Request for speech pathology for child with mild articulation errors such as lisping or no clarity with the following sounds (about ten and/or clusters).
- Behaviours are minor and could be managed by other service providers such as CSRDOs, MCH nurses or PSFOs, e.g. request for psychology for swearing, separation, biting, spitting, hitting, throwing tantrums – which have not been addressed by generic service providers.

Appendix 12: Case Study: Family Links Project

Provider: Broadmeadows Uniting Care, Hume

Funding Source: Commonwealth Department of Family and Community Services

Locality: Moreland and Hume municipalities

Target group: Families with children in 10 nominated child care centres.

Aim: To assist families and children in the very early years of a child's life to prevent the occurrence of serious social problems later.

Purpose: To provide generalist short-term counselling, support and parent education and family strengthening programs.

Duration: May 2000–June 2002.

Overview

Family Links is a parent education and family strengthening program that works with staff and parents in 10 child care centres across the cities of Hume and Moreland. Family Links is an early detection and intervention program, which aims to identify and assist vulnerable families whose child's development or behaviour is of concern.
.
There are 3 components to the program:
- Parenting education and family strengthening
- Case management
- Professional counselling

The Family Links program employs a team of five professionals comprising a coordinator/case manager, a community and parent education worker, two part-time family counsellors and a research/evaluation worker. These staff work with the families and the child care centre staff to produce better family outcomes.

Regular evaluation is an important component of the Family Links program, enabling it to be revised and continuously improved using action research principles.

Uniting Care seeks to develop a model suitable for replication in other communities. They are also planning to be as innovative as possible in the way they record clients' stories and the progress of the project.

This project will enhance Australian understanding of the impact of intervention in the early childhood years.

Appendix 13: Merri Housing Service Children's Program, Northcote

Background

Merri Housing has been researching the needs of children in the Supported Accommodation Assistance Program (SAAP) for the last two to three years. Workers realised that there was a gap in service delivery for children. Workers also observed that while parents have the best intentions in wanting to meet the needs of their children they not always able to do so, because they are trying to cope with their own major difficulties.

In October 1997 the Merri Housing Service decided to respond to the abundant written material and the concerns expressed by Housing Service support workers, by establishing a children's support pilot project.

Profile of Families

The Merri Housing Service provides supported accommodation within a Community Development framework, to individuals and families who, because of their circumstances and experience, are unable to access mainstream services.

Children come into Merri Housing via the Women's Program. Most of the women face multiple issues including drug addiction, mental health problems, domestic violence and poverty. One common thread is that women enter supported housing because they have not been able to cope on their own and organise their day to day life. More often than not translates into an inability to meet the child's most basic needs.

In nearly all cases, women and their children have experienced and/or witnessed domestic violence. While this is of great concern and affects the children's development, children in homeless families are affected by an even wider range of issues, including other forms of abuse, neglect, poverty and isolation.

The majority of the children at Merri Housing have issues in all these areas. When a child experiences deprivation in multiple ways, as well as domestic violence, that child's ability to achieve their potential or even to develop normally is severely compromised.

Workers in the sector are starting to see not only a second generation but a third generation of homeless persons in need of support. It is obvious that children's needs are not being addressed when we see a generation growing up in the system only to continue as part of the same cycle.

Aims of the Program

- To meet the specific support needs of children in families within the Merri Housing Service by providing a children's support worker who understands the developmental needs of children and who will advocate on their behalf
- To assist children in understanding and coping with their recent experience of homelessness and family violence
- To implement individual case plans in collaboration with parents and children

- To develop programs and networks that support the targeted needs of children in the areas of education, health, developmental play, social isolation, links to specialist services and parent education.

Merri Housing's Achievements in Working with Children and Young People

Merri Housing's "best practice" in working with children and young people in supported accommodation is to provide them with a framework that provides a safety net, in order to prevent further cycles of homelessness, domestic violence and poverty.

This is achieved through a case management plan that covers:
- **Education –** The Children's Program has been successful in supporting families at school case meetings and assisting in the organisation of paediatric developmental assessments Funding obtained from the Schools Youth Focus Brokerage Program has provided the children with vital, one-on-one tutoring> This is vital, as nearly all of the children who use the service have learning difficulties, often linked to high absenteeism and having to change schools regularly due to transience.

- **Health –** Many children in families who experience recurring homelessness suffer poor health. During the early stages of setting up a support plan, families are provided with booklets related to health issues such as nutrition, dental care, hygiene and safety.

The Children's Program has been successful in linking families into health services like:
- Darebin Community Health
- Royal Children's Hospital
- Fellows in Community Child Care
- The Gatehouse Centre, Royal Children's Hospital
- Darebin Dental Services
- Darebin Hearing Testing Service
- Maternal and Child Health Services.

When necessary direct support is provided to families in order to keep vital medical appointments.

Appendix 14: Case Study – Health Time Outreach Model

Health Time is a special needs program initially developed and implemented by the Inner South Community Health team in partnership with outreach staff of other relevant services. Staff visit isolated residents of low-cost housing options such as Special Residential Services, caravan parks, rooming houses and low-cost hotels. Health issues identified through work with this group include poor nutrition, poor dental health, drug and alcohol abuse, mental health issues including intellectual disabilities and other chronic health problems. Experience shows that this client group is least likely to access services, despite an overwhelming need, until perhaps the condition reaches crisis.

The Health Time program hopes to address clients' needs, by providing outreach services to residents at their place of residence and offering direct access or referral to a range of health and support services. Core services of the program include general health advice from community nurses, social workers and a dietitian, dental services, physiotherapy and massage, podiatry and provision of nutritious food. Clients can also be linked with visiting housing workers, mental health, drug and alcohol and Centrelink workers.

Program Aim

To improve knowledge of and access to health and support services for tenants residing in low cost accommodation in order to improve their health and well being. Objectives are to:
- Offer a range of health services at Health Time sessions to promote knowledge of and access to services and identify and meet specific health needs
- Increase the number of referrals and attendance at appointments to the health centre
- Improve the nutritional status of these clients
- Increase clients' and health centre staff's knowledge and understanding of clients' issues and the barriers to effective health care
- Develop collaborative networks through linking appropriate support services into Health Time sessions
- Increase health promotion activities to this client group

Program Components

Health Time provides an informal point of contact for health staff and the client group. It is conducted fortnightly at their own place of living. Clients come voluntarily to the session, where they can get free food, a free massage and the opportunity to talk to health centre and other staff for helpful advice or referral. CHC staff ideally include allied health workers, who attend on a rotational basis. Others may be from housing, drug and alcohol or psychiatric services, or Centrelink. Information pamphlets about local services are available.

Staff Roles

All staff can attend Health Time with multiple roles. As general health advocates and representatives of the various services, it is important for staff to be friendly, to initiate conversations with clients, to break down barriers that can exist and to foster mutual trust relationships and be supportive of residents' needs. As members of a team they are responsible for fostering a positive environment. Staff are encouraged to promote the services of the health centre, offer general health advice and refer to GPs and

other services. Staff are also encouraged to promote greater understanding of their particular profession to clients showing how they might benefit from and access that service. Health promotion activities may include information displays, presentations to clients and secondary consultations. The role of the Health Time Coordinator is to establish positive working relationship with managers and owners of the accommodation settings, and to negotiate with these people to hold Health Time days at their venues.

For more information contact
Inner South Community Health Service
18 Mitford Street
St Kilda Vic 3182

Good Shepherd Youth and Family Services

St Kilda Vic 3182

Appendix 15: An Exploring Together Program in Vietnamese

During terms 2 and 3 of 2000, an Exploring Together Program was run in the City of Yarra for Vietnamese families. This was based on the Exploring Together *Preschool Program*, a short-term early intervention program for parents, schools and community agencies to help preschool children with emotional and behavioural problems. The program focuses on supporting parents, enhancing parenting practices, strengthening family units, reducing children's problematic behaviour, developing children's social skills and enhancing their self-esteem. The Preschool Program is based on the Exploring Together *Primary School* Program, which is a well researched and empirically validated program for families with children 5–14 years. The Cottage (BSL) was the lead agency; working in partnership with the Annie Todd Children's Centre and the City of Yarra Family Support Service. The program was conducted in Vietnamese with bilingual workers, and adapted to make it culturally sensitive.

The Exploring Together framework provides for input from families about their particular issues, and in this case, additional time was spent asking participating families firstly to identify what makes a good Vietnamese parent. This discussion was invaluable as everyone began to realise that there is not one, but many, ways in which Vietnamese parents raise their children. Participants were then asked to identify similarities and differences between Australian and Vietnamese parenting styles. Participants were also encouraged to reflect upon the parenting practices they wished to keep from their past, and to explore with facilitators, and with each other, new strategies they might like to try out. Parents were supported to experiment with new strategies and the usual teaching approaches of modelling, coaching and discussion were utilised. As the program progressed, parents identified issues and strategies for their families, in combination with their partners (Exploring Together Programs include two partner evenings). Ultimately the choice was left to parents to decide on the parenting strategies which would work for them.

As with other Exploring Together Programs, parents engaged at different levels. However, a key learning for both participants and facilitators was that the participants themselves felt empowered by being presented with choices and different approaches to parenting. It was clear that cultural appropriateness was something which was decided by the Vietnamese participants (parents in conjunction with bilingual workers). Facilitators took a "one down" position with parents, acknowledging that they *did not know* what would be appropriate but instead would need to learn from participants. In reversing the usual pattern of parent program delivery, the approach was creative and flexible, with much empowerment and discovery along the way.

The program illustrates an innovative approach to adapting a program to meet the needs of different cultural groups. It suggests that decisions about cultural appropriateness and adaptations can be made as the program progresses, provided that there is adequate consultation and appropriate bilingual support.

Appendix 16: Local Links Project developed by Royal Women's Hospital and Dianella Community Health

Local Links is a three-year developmental demonstration project auspiced by the Royal Women's Hospital and Dianella Community Health in Broadmeadows, and funded by the Victorian Department of Human Services (until 30 June 2001).

Objectives of the project

- To enhance the quality of women's experience of pregnancy and early motherhood by reducing social isolation
- To improve women's skills, information and emotional well-being during pregnancy and early motherhood
- To establish and trial a protocol that strengthens links between the Royal Women's Hospital and community service providers
- To enhance the quality of services provided to women attending the Royal Women's Hospital Birthing Services

Since it was established, Local Links has provided services to around 700 women in the following postcode areas: 3046 (Hadfield, Glenroy, Oak Park), 3047 (Upfield, Jacana, Dallas, Broadmeadows, Broadmeadows South) and 3048 (Coolaroo, Meadow Heights).

The women's ages ranged from 16 to 46 years, with an average of 28 years. The majority were partnered (85% either married or in a de facto relationship); almost three-quarters were born in a country other than Australia, with women from Turkey, Lebanon and Iran being the largest groups. Just over one-third of the women were dependent on a benefit or pension.

A planning workshop in February 2001 of more than 30 service providers and reference group members, agreed that the project's critical strengths were:
- women-led local groups, which had funded transport and childcare
- bilingual health workers, being part of the service team, not just working as interpreters
- coordination and management which could undertake such tasks as pursuing funding, and maintaining intersectoral links between community and the hospital
- early intervention for women with identified needs
- continuity of care from prenatal to postnatal and then even to playgroup with a broader social role; and continuity between the acute and social health sectors.

Points from Year 2 Evaluation Report

The year 2 evaluation report noted that the Local Links model takes account of women's lives by offering childcare and transport and by providing groups at appropriate times and venues. As a result of Local Links-initiated groups, other agencies are beginning to extend into new areas, such as leadership training for Arabic-speaking women to develop skills and support women in their communities. This is likely to have a positive impact long term on women's and children's health.

Bridging Antenatal and Postnatal Services

A key feature of Local Links is developing ways of bridging the gap between ante- and post-natal services. The involvement of Maternal and Child Health (MCH) nurses

in the ante-natal groups has been especially beneficial in this regard. M&CH services are more aware of the needs and cultural issues for some groups of women and midwives gain confidence in facilitating groups. Mothers find it easier to contact MCH services after the birth of their baby, because they have met the nurse and are more familiar with the service.

Local Links has established partnerships with local agencies and worked collaboratively with them. Local Links' credibility in the local area is due to the project's identification of needs, the success of group work, and the time put into establishing partnerships and links.

The team approach of Local Links has been important, but the role of the bilingual health workers has been crucial, in breaking down stereotypes and encouraging agencies to develop appropriate ways to include groups of isolated women in mainstream services. They have also supported women in gaining access to childbirth education, social support, and general health and service information that will benefit their own and their children's health.

Discussion

Local Links is a timely project embodying key emphases of current Commonwealth and state government priorities — the importance of a social approach to maternal health; and a strong emphasis on early intervention, parenting and relationships. In the first two years, considerable progress has been made towards fulfilling the key objectives of the project, despite the complexities of the service system.

The major elements that make Local Links successful are:
- local solutions to local problems;
- the efficacy of service partnerships; and
- capacity building in the local community.

Appendix 17: Yarra Community Development Playgroups

The Early Childhood parenting playgroups were established in City of Yarra in 2000 in an effort to provide parenting support for disadvantaged families that were resistant to accessing established services for help or information with their children.

Research was done to ascertain where these families were living and the best location for the planned groups. It was decided to locate these playgroups at the Neighbourhood Houses on the Collingwood high-rise estate and at Belgium Avenue, opposite the Richmond high-rise estate. These locations were chosen because it was important to use a venue that the local community felt that they "owned" and was accessible.

It was also important to take into account the various cultural backgrounds of these families. In Richmond, the team decided to utilise the services of two East Timorese workers and a Vietnamese worker. Their roles were to welcome and engage new families, as well as to interpret, so that information and support about parenting could be given to these families in an informal, non-threatening, non-stigmatising manner.

Many of these families may have come from countries or backgrounds where established formal information and support agencies, were threatening to them and as a result they were reluctant to use these services. This meant that there were disadvantaged families living in the high-rise estates with young children in the 0-4 year age group that were isolated and not accessing any mainstream services.

The early childhood parenting playgroups were designed to provide an informal, relaxed atmosphere for families to come and build links with their local community.

There was no formal assessment and intake procedure, as this might have frightened many families away. In many instances, a new family attended one of the playgroups for two or three weeks before the workers asked for details about their name, address, phone number and family situation.

The groups operate on an "open door" policy so that families feel welcome to drop in, and assess the situation for themselves. Many families "watched" the groups operate, before deciding that they felt comfortable enough to join in, and started attending regularly.

The workers had to earn the trust of these families so that they felt comfortable about disclosing any issues about parenting or their families. The playgroup model was very successful at doing this, and staff were able to refer families to appropriate support services that otherwise they would never have accessed. Staff from relevant support services were also invited to attend the playgroups from time to time, so that the families could familiarise themselves with these services in an atmosphere that felt safe and relaxed. Then, if a referral to these services was necessary in the future, the families would be more likely to remain engaged.

In conjunction with the local community health centres in Richmond & North Yarra, staff decided to run some early parenting groups during the playgroup time, at Richmond. Workers from the community health centres ran several parenting sessions, whilst at the same time the playgroup continued, with the help of some childcare workers. This proved hugely successful so staff decided to incorporate some community education sessions in to the playgroup model. Dental care and

baby massage, basic first aid for accidents, CPR and use of medications and women's health issues were among the topics covered.

These sessions were very well attended by the families and the evaluations done indicated that they preferred this approach and would not be willing to go to more formal venues for this information or education.

The success of this model at engaging disadvantaged families will influence the planning and staffing for early childhood parenting play groups in 2001 in other areas of Yarra, as it is very important to have workers who are not only experienced but also from relevant cultural backgrounds. The staff hope to expand this model to incorporate more parenting groups and community education sessions to be run parallel or within the early childhood parenting playgroups in the future. There is also potential to link older members of the community who may also be socially isolated with these families, who in many instances do not have any extended family supports, and to consider whether the occasional playgroup held on weekends would be appropriate. To run groups like this involves planning and integrating many services so that the best long-term outcomes can be achieved for these families.

Information contributed by Leecy Wolan
Early Childhood Worker
City of Yarra

Appendix 18: *Good Beginnings* National Parenting Project

One model of home visiting in the Brotherhood's Phase One Report's list of promising programs has received considerable federal and private funding and attracted much interest – the **Good Beginnings National Parenting Project**. In response to the number of parents who are isolated and lack social networks to help them in the challenging tasks of parenting, the Good Beginnings Volunteer Home Visiting and Parenting Program was developed. It provides community-based services to meet the needs of families with young children for social support information on local resources and child development. Projects undertaken by Good Beginnings include home visiting by trained volunteers and volunteer home visiting for culturally specific groups (e.g. Vietnamese and Chinese). The Good Beginnings Connect Programs work with local communities to improve social environments that support families with young children.

The Good Beginnings pilot phase and its expansion phase have been financially assisted by the Commonwealth Department of Family and Community Services (FaCS), the National Association for the Prevention of Child Abuse and Neglect (NAPCAN), philanthropic foundations and fund-raising activities. The Program has grown rapidly since the successful evaluation of the pilot programs (which were conducted in Katherine (Northern Territory), inner-western Sydney, Hobart and Moe (regional Victoria). The National Parenting Program has an expert Reference Group which includes some of the most experienced practitioners and researchers in the area of child and family services. A number of core principles have been developed through wide consultation.

The Good Beginnings Volunteer Home Visiting and Parenting Programs are place-specific, and community support is essential. Programs are developed and maintained in partnership with local government and community agencies. Programs can operate under a variety of management structures, based on best practice guidelines which are free and readily obtainable, and supported by other resources such as volunteer training programs, videos and workbooks. A number of programs have been developed in partnership with corporate bodies, local business, philanthropy and individuals to ensure program sustainability (Good Beginnings Australia, 2001).

***Good Beginnings* National Parenting Project**
Suite 32, 8-24 Kippax Street, Surrey Hills NSW 2010
Website: www.goodbeginnings.net.au

Appendix 19: Support at Home for Early Language and Literacies (SHELLS)

SHELLS is an early literacy intervention designed to empower the families of young children between birth and three years of age in their role as their children's first literacy teachers. Formerly known as the Home-based Emergent Literacy Program, (HELP, see Appendix 20), by 2001 SHELLS operates with both Indigenous and non-Indigenous families in rural and regional areas of NSW. It is claimed that the collaborative and flexible model that has been developed for SHELLS has the potential to assist a range of families from a range of social, cultural, economic and geographical settings in supporting their children's early literacy learning.

The focus of SHELLS is families with children under the age of three who live in rural and regional areas, and this may mean that it is not as suitable for metropolitan areas. However SHELLS is designed to operate differently and responsively in varying contexts, depending on the interests, needs, and traditions/cultures of participants. It offers intensive support to parents/carers, with contacts of various types offered to participants each week for 40 weeks per year for up to three years. Contact types include group meetings, telephone calls, a monthly newsletter, home visits and information via community radio. Teleconferences, e-mail and other distance learning strategies are used to maintain contact between sites.

The program is based on everyday activities and experiences such as talking with children, reading to them, singing with them, letting them draw, and involving them in functional, social experiences that involve literacy (e.g. shopping, telephoning, choosing TV programs, and reading emails).

Facilitators are recruited from the local population. It is essential that they have the acceptance of the community in which they are working. Where possible, they also have an early childhood qualification.

For further information, contact

SHELLS
School of Humanities
Central Coast Campus
PO Box 127 Chittaway Rd,
Ourimbah NSW 2258

Appendix 20: Home-Based Emergent Literacy Program (H.E.L.P.)

Note: HELP was the precursor to SHELLS, described in Appendix 19.

- HELP is a program in emergent literacy designed for parents who have children under the age of 3 years, based on the belief that children's success in literacy depends mainly on what they have learned about reading and writing *before* they reach school. This is a three-year educational intervention designed by Dr Laurie Machine to support children's growth into literacy and to empower parents in their role as their child's first literacy teachers. It began in 1997.. Early childhood academics from the University of Newcastle oversee all aspects of the project.

The project has been developed in Australia to meet specific needs of Australian families and communities, not imparted and imposed. It is flexible and evolving, not rigid or imposed. It involves ongoing contact and support for up to three years, unlike many interventions which are of short duration and delivered intensively (e.g. once a week for 8 weeks).

Parents have been able to participate free of charge, due to the generosity of funding bodies. HELP is a research project supported by the University of Newcastle, The Ian Potter Foundation and The Book Garden.

Appendix 21: The Vision of the Brotherhood of St Laurence

The Vision of the Brotherhood of St Laurence

Established during the Great Depression, the Brotherhood of St Laurence was the vision and creation of Fr Gerard Tucker, a man who combined his Christian faith with a fierce determination to end social injustice. The BSL has developed into an independent organisation with strong Anglican and community links. Today, we continue to fight for an Australia free of poverty.

The Vision: Australia free of poverty

The Brotherhood of St Laurence will work with others to create:
- an inclusive society in which everyone is treated with dignity and respect
- a compassionate and just society which challenges inequity
- connected communities in which we share responsibility for each other
- a sustainable society for our generation and future generations.

In working towards an Australia free of poverty, we recognise the indigenous custodians of this country. We are committed to understanding the effects of the dispossession of indigenous Australians and to achieving reconciliation.

How we do it

- **Ensure that what we do for one we do for many**
  Wherever we work with people who are disadvantaged or excluded, we will use what we learn to improve the situation for others. We will share our service, research and advocacy experience to bring about change towards a more inclusive society.

- **Establish the eradication of poverty as a national priority**
  We will establish the eradication of poverty as a primary objective for all governments and communities in Australia. Our work will be principally informed by the experiences of those who are disadvantaged, but we will seek to involve all people in establishing this national priority.

- **Promote a movement for social change**
  In partnership with others, we will promote a movement for a just and compassionate society. Within our workplace, we will develop models of service provision, leadership and participation that embody our values and aspirations.

- **Support a sustainable society**
  In keeping with our global responsibilities, we will work towards a society that balances social, environmental and economic benefits. In all our work, we will contribute to change that supports communities, protects the natural environment and promotes good governance.

Appendix 22: DHS Provision for Expansion of Crisis and Transitional SAAP in Northern Metropolitan Region

This crisis initiative constitutes a new service model for SAAP (Supported Accommodation Assistance Program) with new crisis support components being funded at a level more intensive than the usual transitional assistance. It is intended that this new service model be utilised in the provision of short-term, intensive support for SAAP clients who require immediate assistance and access to accommodation. Different regions may develop differing crisis models in response to local needs.

Submissions were sought in the outer metropolitan areas of Moreland/Hume for a developmental approach moving towards an improved area based service system; and to contribute to more effective use of Housing Establishment Funds (HEF). The model needs to demonstrate ability to incorporate early intervention/prevention and direct service provision; and enhanced linkages within and beyond the core homeless system of SAAP and Transitional Housing managers.